Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2132SNF	A. BUILDING _____ B. WING _____	C 07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HILLS HEALTH CARE CTR	3450 N. BUFFALO DRIVE LAS VEGAS, NV 89129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments Surveyor: 27286 This Statement of Deficiencies was generated as a result of complaint investigation conducted at your facility on 7/28/09 and finalized on 7/29/09 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. The following six complaints were investigated and unsubstantiated: Complaint #NV00019398 Complaint #NV00021356 Complaint #NV00021882 Complaint #NV00022316 Complaint #NV00022495 Complaint #NV00022628 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies were identified. No further action is necessary. Please keep this copy for your records.	Z 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE